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PROGRESS IN PRIVATE PRACTICE. IS SOCIALIZATION OF MEDICINE NEEDED?

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To one who himself earnestly believes in the general elimination of the profit motive and the equitable distribution among all citizens of the advantages of a rich civilization, the proposal to begin by a destruction of the private practice of medicine arouses a mixture of feelings among which not the least is apprehension. Conscious, as is every physician, of the social inadequacy of certain phases of the present situation and of the occasional occurrence of instances of flagrant injustice to individuals, one is also conscious of the great mass of conscientious, self-sacrificing and on the whole poorly paid endeavor on the part of a body of men in whom the profit motive is actually as well as traditionally of secondary importance. The question at once arises—is it wise to begin socialization where perhaps the need is least and where a failure to achieve an adequate adjustment will act as a tremendous damper on all enthusiasm for further attempts at much needed social reform in other fields?

This leads to a direct attempt to appraise the adequacy of the present system of private practice. Constant criticism is being levelled at the profession by intelligent laymen—criticism that is often well deserved and not to be disregarded. Such unfavorable comment is of the greatest practical value and will add to the efforts of the best minds in the profession that effective stimulus from without which will force the conclusion that if the profession will not itself clean house it may be compelled to do so by public action. This would mean the loss to the profession of its much cherished liberty in the direction of its own affairs.

The recent article by Professor Laski entitled "The Decline of the Professions" (*Harper's*, November, 1935) is an excellent example of this type of constructive criticism. The ability of the physician to contradict on the basis of his own experience this or that individual statement in such an article is not sufficient ground for discounting the whole, especially as some of the arraignment must be admitted by all. But is "the individualistic organization" of the profession "fatal to the fulfillment of its function" as Professor Laski maintains?

On this question the physician with an extensive consulting and hospital practice is in a position to pass judgment. He is intimately acquainted with the problems of the active practitioners in his own locality. While it may be possible that his locality is not representative of the country as a whole, frequent contacts with colleagues at national conventions and otherwise make him feel that it probably is. His first hand familiarity with the work of his local confreres makes his opinion in this matter of much greater weight than that of a layman, however well versed he may be in general social and economic problems. Let us then, through the eyes of such a physician, examine the average practitioner in one of the fairly large eastern American cities as well as in the adjoining towns and countryside. Our first impression is that he is a rather admirable fellow who quietly gives evidence of being well trained and up to date, though we note a few glaring examples of the opposite. He is quite evidently high in the esteem and affection of his patients. Is he, as he has been called, "a prisoner serving a life sentence"? Hardly—in fact quite the reverse. Held down by heavy responsibility he certainly is, but he carries it gaily and is quite his own master. On occasions he is able to negotiate with colleagues for mutual help in arranging vacations, trips to medical centers and the like.

Is such a man dependent upon factors extraneous to his purely technical skill in making his way? He most certainly is, but these are not social accomplishments, an attractive wife or skill at golf, but rather what we may call his personality—his ability to make people like him and what is more important, trust him—his ability to be sincerely kind, thoughtful and understanding. Without these qualities scientific skill is wasted, for, as every practitioner knows, the art is of equal importance with the science of medicine. To be effective medical advice and treatment must be given with kindness

and with care—always with the knowledge that the sick human being is frightened and impressionable, and that the fear and discouragement caused by a chance word may nullify weeks of effort. To the average patient not under an anaesthetic, what is said is often of more importance than what is done or prescribed. The achievements of such a man as William Osler depended fully as much on his benevolent understanding of human nature as on his strictly scientific ability. If all this be true, what is the effect on our average practitioner of his independent status with its lack of financial security? It is just this: He realizes that he must treat the Joneses, the Browns and the Smiths kindly, considerately and effectively or they will at once forsake him for his colleague around the corner. What if he had "security"? He could then afford to slight his patients a bit and the quality of his work would inevitably suffer.

Then there is the alleged inability of the average practitioner to keep up to date. In every urban and most rural communities hospital facilities are available with charity work to be done and always a place for the man who is well trained and willing to work. Opportunities for continued training and daily contact with the best type of work are thus within the reach of a very large proportion of the profession. For those to whom, because of residence in remote districts, such hospital positions are not available, there are the bi-weekly and monthly clinical meetings open to all practitioners, the duty of reading current medical literature and the routine contacts with consultants, which keep a man's interest stimulated and his information up to date. It is true that there are men who because of financial stringency are unwilling to risk attending meetings lest they lose a patient to a colleague. In many such cases the true reason for their non-attendance is intellectual inertia and a call at their offices next day is likely to disclose the fact that they have gone fishing or to the races. Furthermore, at the present time public education in medical matters is reaching a point such that the man who is known not to keep up, not to hold hospital appointments and not to call consultants freely suffers by comparison with his more progressive colleagues and by his short-sighted conservatism, defeats his own ends.

A few years ago a young man with average training entered general practice in a suburban community in which several older physicians had been established for years. He had no financial backing except what he was able to borrow. He obtained an opportunity to work in the Out-Patient Department of the largest general hospital in the adjoining city (an opportunity which, by the way, has always been open to any graduate of a good medical school who is licensed to practice in the state). Faithful work made his position permanent and thus brought him frequently in contact with the leaders of his profession. In his office his physical examinations were complete and well recorded as had been taught him by those poorly paid young enthusiasts who helped transmit to him his heritage of idealism along with his routine training in medical school and hospital. His problem cases always received adequate study, with laboratory work as needed either by himself or when necessary with the aid of the State Laboratory—a service free to physicians. His patients who needed it were urged to go to the hospital rather than be inadequately treated at home, and he called consultants whenever their help was needed even if he had to cut down his own fees to help the patient pay for the consultations or in rare instances to ask the consultants, whom he had come to know and trust, to join him in giving charity to a person in need. What has been the result? He has won the confidence of his community, people who in England would be called "lower middle class" who have been quick to recognize the difference between his painstaking methods and the slip-shod work of his older colleagues; and it may be added that he now owns his house and has all the work that he can do. This man is a typical product of the present system. Under State medicine, lacking the necessity to do his level best, it is probable that he could not, or at least that he would not have reached his present level of perfection as a practitioner. His counterpart is seen in most American communities although it must be admitted that he is superior to the "average practitioner" who has been the main object of this discussion.

If then we admit that under the present system there is ample opportunity for the earnest practitioner to develop himself and every incentive to render good and up-to-date service—we must still answer the charge that there is in actual practice often a great contrast between the treatment accorded the rich and the poor. This criticism is many times justified. The present system of free and low priced hospital beds for the needy is a

partial but by no means adequate answer. It is a commonplace that self-respecting people of moderate means who will not accept charity often fail to receive proper attention, as the cost of x-ray examinations, consultations and other forms of special investigation and treatment is prohibitive. Earnest efforts to improve this situation are being made as, for example, the establishment of hospitals in which a fixed low price is charged, such as the Baker Memorial Hospital in Boston. The questionable success of that form of partially socialized medicine, the British Panel System, which has been developed to meet this need is a warning that an ill-considered scheme may be worse than none at all.

Professor Laski cites the example of the rich man charged with drunken driving who can bring a private physician to his aid to counter police evidence. In this connection it is of interest that in the town where lives the successful young practitioner whose work has just been discussed a very rich man was recently taken up, charged with driving while under the influence of liquor. As allowed by law he summoned his own physician, a well known consultant, who examined him elaborately and found his condition to be normal at the time of his examination. In court it was discovered that this doctor had attended the judge and was known and respected by him. Yet, in spite of his testimony, the man was convicted, heavily fined and deprived of his license to drive, and the large fee which he had to pay to his physician availed him nothing.

Of other criticisms often aimed at physicians that which relates to what is known as "medical etiquette" is one of the commonest. In spite of a strong conviction among the laity to the contrary this etiquette, so called, seldom causes hardship to the patient and is a means of preserving harmony and understanding between physicians where a lack of such harmony might easily be the cause of untold havoc. When doctors work at cross purposes it is the patient who suffers. The commonest complaint of the layman is that he cannot have the doctor whose services he desires. For example, Doctor A refuses to treat him now that Doctor B, his family physician, has returned from his holiday—or because Doctor A has been Doctor B's consultant in the case. The simple fact is that a misunderstanding between Doctors A and B would be a real calamity and that the patient can always dismiss them both and call in Doctors C, D or E who will respond with no offence to anyone. If, as in such an instance, there arise occasional circumstances under the present system in which a slight limitation of absolutely free choice of a physician exists, we must remember that State medicine means a much greater limitation. Even "in the panel system, we have in the past few years, seen the patient's liberty to change his doctor greatly restricted" to quote from the writings of an English colleague. So much for "medical etiquette"—hardly the "labyrinth of complicated punctilio" that it has been called.

As regards the cults, Osteopathy, Chiropractic and the rest, honest endeavors to find the truth about them have brought to light so much crass commercialism and such a lack of demonstrable scientific foundation that the physician can only deplore the gullibility of the public. He must recognize, however, that further improvement in medical practice and the resulting increase in public confidence is the only means at his disposal for combatting these evils, and that all attempts at direct opposition will be interpreted as persecution. It is difficult to see in what way the establishment of State medicine would improve the situation.

If, then, the work of the physician today under the system of independent private practice is not on the average so poor; if, in fact, he is doing increasingly better and more scientific work as the years go by, fulfilling, as he must, higher and higher technical requirements to be admitted to practice and preserving, as he does, the lofty ideals that are his heritage—one can hardly say that the profession of medicine is in a state of "decline." If we admit the existence of many evils still to be corrected, we can still claim the existence of an honest effort in this direction. As far as the evil of commercialism is concerned, while we may agree that many shameful instances exist, we can still hold that in the rank and file of the profession the profit motive is subordinated as it is in no other group of independent individuals.

To really improve such a situation a plan for State medicine must be a very perfect one. Anything which limits the free choice of his physician by the patient will be a step backwards, and anything which takes away from the physician the necessity of "making good" in the eyes of his patient and of giving him his level best of attention and kindness as well as of technical skill will be retrogression indeed. Anyone who has had experience with medicine as practiced in the great public services, the Army and Navy, realizes that the

situation there is far from satisfactory from both these points of view. Let us mention only in passing the possibilities of gross injustice that are ever present under any sort of bureaucratic control and in this connection let us quote the words of another Englishman, the present Lord Chief Justice: "The treatment of the panel doctors under the National Health Insurance Acts is pure despotism."

In conclusion we may freely admit that socialization of society in general is highly desirable however difficult it may be to attain. We may further admit that if it could be successfully applied to medicine, socialization would represent an advance over the relatively satisfactory and consistently improving situation which it obtains at present. Every right-minded physician would be glad to be rid of the commercial side of his practice. Nevertheless we must bear in mind the immense difficulties in the way of success in this field and the positive harm that must result from anything short of success. Therefore, in view of the fact that in no group of independent individuals in our modern civilization is the profit motive less prominent and the need of socialization less urgent than it is in the medical profession, while at the same time in no group is socialization less likely to achieve success, we are forced to conclude that the field of medical practice is not the place to make the start.

PHYSIOLOGICAL SURGERY OF THE NERVOUS SYSTEM*

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There are three general types of surgical operations; those aimed at removing pathological structures, such as tumors or abscesses, those aimed at restoring normal anatomical relationships, in which group belong most orthopedic and plastic operations, and finally, those designed to correct or compensate for physiological or functional disturbances. In the surgery of the nervous system, as in other branches, operations of the first type are the most common. Operations of the second type are represented only by nerve sutures, for regeneration does not take place in the central nervous system. But operations of the third type, extremely rare in other departments of surgery, are assuming an increasing importance in the domain of neurological surgery.

The most important of these operations are those for the relief of pain. Simple peripheral neurectomies are now seldom used, the important exception being section of sensory nerves supplying the foot in the treatment of endarteritis. Posterior root section is sometimes indicated in selected cases of pain in the neck and trunk. Of course, allowance must be made for the overlap of neighboring dermatomes. The operation is most frequently performed for the relief of trigeminal neuralgia, and it represents one of the major surgical triumphs of the century. Modifications of the operation permit retention of sensation in unaffected branches of the trigeminal nerve. A recent substitute for the operation which holds great promise consists of the insertion of a needle through the foramen under anesthesia by means of X-ray control, and the destruction of part or all of the ganglion by chemical or physical means. This obviates the discomfort and loss of time occasioned by the operation, and all of the pain and most of the uncertainty of the old alcohol injections.

Operations have also been performed on the spinal cord for the relief of pain. The most important of these is section of the anterolateral columns, which is an extremely effective and surprisingly innocuous method of treating intractable pain in the pelvis, legs, and abdomen. It is less successful in the treatment of pain in the arms, but recently an operation has been introduced by which the "pain" fibers may be severed by a midline incision through the commissure, where they are crossing to enter the spinothalamic tracts, which has yielded good results.

Among other disagreeable sensations, the vertigo of chronic labyrinthitis has been treated with great success by section of the eighth nerve. A more conservative operation recently introduced consists in destruction of the semicircular canals in the petrous bone through the middle fossa—a technically easier and safer operation. Severe tinnitus may be relieved by similar means.

Of motor phenomena, epilepsy is the one which has been the object of countless surgical procedures, with occasional successes. The subject is too large to go into here. Severe torticollis is often satisfactorily relieved by section of both spinal accessories and two or three anterior cervical roots on

*Delivered at the Arnold Laboratory of Brown University at a Medical Colloquium under the Division of University Health.

both sides—an operation which leads to astonishingly slight disability. Recently athetosis and dystonia have been successfully treated by section of extrapyramidal motor tracts in the spinal cord.

An entirely different type of problem, which in the past has been considered hopeless, is presented by non-obstructive or idiopathic hydrocephalus. This has been relieved in many instances by resection of the choroid plexuses by open operation. The mortality is high, however, and much cortical damage is inevitable. A promising new procedure which is certainly far safer and apparently quite as successful, consists in the coagulation of the choroid plexuses through a special endoscope.

THE DIAGNOSIS AND MEDICAL MANAGEMENT OF DIAPHRAGMATIC HERNIA*

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This contribution is based on clinical observations made in the examination and treatment of patients presenting vague symptoms of dyspepsia, in whom, in the course of study of the alimentary canal, a diaphragmatic hernia of the esophageal hiatus type was encountered. Such a hernia may be described as a protrusion of a portion of the fundus of the stomach, occasionally with other abdominal viscera, into the thoracic cavity through the esophageal orifice of the diaphragm. The opening in the diaphragm may be other than the esophageal orifice; it may be a natural opening which has become enlarged or an artificial one acquired by injury.

Giffin[1] found 650 diaphragmatic hernias reported in the literature up to 1912. Most of these cases were discovered at autopsy and but 15 had been correctly diagnosed clinically. In 1924, Carman and Fineman[2] reported 20 cases observed at the Mayo Clinic up to then and estimated that the incidence was 1 in 18,000 patients. Within the past 10 years, numerous cases have been reported by Hedblom,[3] Akerlund,[4] Harrington[5] and Truesdale;[6] the last named reporting a large series of surgically treated cases in both children and adults.

During the past 12 years, in both hospital and private practice, I have observed 53 cases of esophageal diaphragmatic hernia in about 6,000 patients with gastro-intestinal complaints, an incidence of 1 to 113. The diagnosis in all of these cases was made definite with the aid of the Roentgen ray. The age and sex of the patients in this series is shown in Table I. The majority of these patients are of the age when one may suspect ulcer, cholecystitis, cardiac disease, cancer of the alimentary canal, or pernicious anemia.

Table I

AGE AND SEX INCIDENCE

	Cases	Males	Per Cent	Females	Per Cent
20 to 30 years	3	3	100	...	...
30 to 40 years	7	2	29	5	71
40 to 50 years	20	5	25	15	75
50 to 60 years	16	4	25	12	75
60 years and over	7	3	43	4	57
Total	53	17	32	36	68

Diaphragmatic hernia is of interest to the internist, the surgeon and the roentgenologist because the symptoms frequently may be obscure and are easily confused with those of other diseases. Its possible presence should be always considered in the differential diagnosis of abdominal and thoracic conditions and in unexplained anemia. Anemia in these cases is due to mild but frequent hemorrhage from erosions of the mucous membrane, especially during attacks of vomiting or severe coughing. The erosions are caused by mechanical injury to the stomach because of its unnatural situation, or by interference with its blood supply due to the stricture at the esophageal orifice and may progress to actual ulceration and occasionally to carcinoma. Truesdale,[7] Harrington,[8] Hurst[9] and Schilling[10] report cases of ulcer formation within the constricted area of the stomach. I have observed two cases complicated by gastric ulcer, one in a man aged 55 and the other in a man aged 70; the latter developing carcinoma at the site of the ulcer three years later. Another gastric cancer associated with a diaphragmatic hernia was seen in an elderly woman. Bock[11] reports 10 cases of secondary anemia caused by bleeding in cases of diaphragmatic hernia.

Most of the correctly diagnosed cases have been reported within the last ten years. This has been due to the better appreciation of these cases by the

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clinician in differential diagnosis of vague complaints referred to the upper abdomen and lower chest, to the improved methods of Roentgen ray diagnosis, and to the more painstaking abdominal exploration by surgeons during operations for other conditions.

The classifications of diaphragmatic hernia are based on embryology, etiology or pathological anatomy. The classification of Dr. Stuart W. Harrington[5] is probably the best since it takes into consideration the clinical history, which may be the most important factor in diagnosis and treatment. This classification consists of two main groups: the Non-traumatic, which may be congenital or acquired, true or false; and the Traumatic, due to direct or indirect injury, also true or false.

Akerlund[4] classifies esophageal orifice herniae into three sub-groups: those with a congenitally short esophagus, producing the so-called "thoracic stomach"; the para-esophageal type in which the lower end of the esophagus remains fixed and variable amounts of stomach herniate through the ring along side of it; and those in which the lower end of the esophagus with more or less of the stomach prolapses through the opening. Thoracic stomach is a very rare occurrence. The majority of the cases reported belong to the last two sub-groups.

Etiology and Pathogenesis of Symptoms

Diaphragmatic hernia is due to congenital weakness or to mal-development of the diaphragm, to increased intra-abdominal pressure, or to trauma. Females are more likely to acquire an esophageal diaphragmatic hernia than males. Embryologically, the stomach is a thoracic organ which later migrates into the abdomen. The various parts of the diaphragm meet and fuse together leaving small openings for the passage of the aorta, the large blood vessels, the esophagus and the nerves. Delay in the descent of the stomach at the time the diaphragm fuses may cause a part of the stomach to remain in the thoracic cavity. There may be an enlargement of the esophageal opening of the diaphragm creating a congenital weakness in the esophageal ring. This predisposes to hernia formation either at birth or at any time during life.

Diaphragmatic hernia may arise as the result of increased intra-abdominal pressure, of which the most common causes are sudden and severe trauma to the chest or abdomen, pregnancy, constipation, severe coughing or straining, prolonged physical exertion, chronic cough, hypertrophy of the prostate, wearing of tight corsets, ascites, kyphosis and megacolon.

Most diaphragmatic hernias are found on the left side. This may be explained by the fact that the right side of the diaphragm is protected from below by the liver. The left side is constantly in contact with the stomach which by its free motility tends to expose the left side.

The size of the hernia depends on such factors as the width of the opening in the diaphragm, the habitus of the patient, the degree of intra-abdominal tension and the amount of food and gas in the stomach. The size of the hernia also varies with the position of the patient, being largest in the recumbent position and smallest or entirely absent in the erect position. Some of the herniae in my series have been observed over a period of ten years with no apparent increase in size. Nearly every organ in the abdomen except the rectum and the bladder have been reported to herniate through the diaphragm. Usually, however, the stomach alone, very rarely the colon alone, and occasionally the stomach and the colon together are found in the hernial sac.

The presence of a hernia in the thoracic cavity displaces the organs normally situated there and may cause cardio-respiratory symptoms. The content of the hernia may displace the heart toward the right and in severe cases causes collapse of the left lung. The hernia may give rise to severe digestive symptoms that may simulate peptic ulcer, gastric cancer, esophageal obstruction, gall-bladder disease, pancreatitis, appendicitis, intestinal stasis and obstruction. Spasm of the diaphragm, with obstruction to the blood supply of the herniated portion of the stomach, may occur and predispose to erosions, ulcerations or "hour-glass" deformity of the stomach or interference with its motility. The hernia may encroach upon the lower portion of the esophagus and cause dysphagia, erosion or ulceration of the esophagus. The pressure of the hernia on the lower esophagus may also interfere with eructation or vomiting. As the majority of the cases seen are in the cancer and ulcer age, a clinical diagnosis of cancer or ulcer of the esophagus or stomach may seem perfectly reasonable. A spasm of the left side of the diaphragm, associated with irritation of the phrenic nerve, may cause pain of a severe type radiating to the left shoulder and down the arm, simulating an attack of angina pectoris. Symptoms of cardiac impairment such as palpitation, tachycardia and cyanosis may be present.

Symptoms

The symptoms of a diaphragmatic hernia are frequently indefinite and readily confused with those of other disease entities. This is due to the various structures that are involved in the hernia, its size and the degree of encroachment upon the thoracic organs. The symptoms in each case therefore depend on the functional impairment of the herniated abdominal viscera or organs, the degree of impairment of the normal function or motion of the diaphragm, and the degree of pressure which the hernia exerts on the surrounding structures in the thoracic cavity: the heart, lungs and esophagus. Table II illustrates the variability of symptoms in diaphragmatic hernia. In some cases, the symptoms may be very mild and easily overlooked, the condition may be accidently found in the course of a Roentgen ray examination of the digestive tract, of the chest, or in the course of exploration during an abdominal operation. Not infrequently cases have been reported where the first symptoms of a hernia of years' duration were those of acute obstruction. When symptoms are present, they may be cardio-vascular, respiratory, gastric or abdominal. When the symptoms are thoracic, cardio-vascular disease, pulmonary tuberculosis, and other lung conditions are usually suspected. The patients commonly complain of substernal distress, a sense of fullness or pain of a pressing nature, varying in degree. The pain may radiate to the back, the sides, and the left shoulder and arm. Twelve patients of this series presented symptoms of severe attacks of substernal pain with radiation to the back, neck, left shoulder and left arm, and were often treated for angina pectoris without relief. Quite often the patient notes that the symptoms are aggravated by the ingesion of either a small meal of coarse food or a full and heavy meal. Many patients avoid lying down immediately after meals for fear of initiating an attack. Belching, bloating, nausea and vomiting may be associated symptoms. Ten patients of this series often required morphia during the attacks. Indeed, the pain may be so severe and agonizing that a diagnosis of biliary colic is made. Some patients obtain relief by taking hot drinks, alkalies, by taking a rest in a semi-erect posture or by walking around intermittently during the meal. These measures often prove effective because during meals these patients experience substernal distress due to the hernia beginning to fill with food. Taking a warm drink, resting, or getting up and walking around for a short while gives the hernia a chance to reduce itself with a resultant disappearance of symptoms. Ritvo[12] found this to be a helpful sign in the diagnosis of diaphragmatic hernia. In many cases the attacks may occur periodically with distress simulating the pain of peptic ulcer. Regurgitation, heartburn, gas, belching and vomiting are frequently complained of. Hematemesis is not an infrequent occurrence and occult blood in the stool may be detected at times in about one-half the cases thus leading one to suspect the presence of an ulcer or gastric cancer.

Table II

Symptoms	Number of Cases	Per Cent
Postprandial distress or pain	48	90
Substernal distress or pain	43	81
Upper abdominal distress or pain	37	70
Nocturial distress or pain	35	66
Alkali relief	33	62
Vomiting	28	53
Heartburn	27	51
Bloating and belching	25	47
Weakness	23	43
Dyspnea, palpitation, tachycardia or cough	22	42
"A lump in lower throat" or dysphagia	14	26
Hunger pain	12	23
Anemia	12	23
Hematemesis	11	21
Tarry or black stools	9	17
Loss of weight	8	15
Overweight	6	11
Constipation	6	11

In diaphragmatic hernia the appetite is generally not impaired, an important point in the differential diagnosis between diaphragmatic hernia and carcinoma. The weight loss, if present, is due to voluntary abstention from food for fear of initiating an attack. There may be attacks of vomiting and at times hematemesis. The presence of blood in the vomitus is due to inflammation or erosions of the gastric mucosa in the herniated portion of the stomach, to the presence of gastric ulcer or to erosions or ulcerations in the lower portion of the esophagus.

The symptomatology most frequently encountered in these cases simulates, in order of frequency: peptic ulcer, gall-bladder disease, cardio-vascular disease, disease of the esophagus and pernicious anemia.

Physical Signs

In the small, uncomplicated hernias physical signs may be entirely absent. In the large hernias the physical signs are chiefly thoracic, due to the encroachment by the hernial content upon the thoracic organs. Pneumo-thorax, hydro-thorax or a new growth may be suspected. Displacement of the

heart toward the right, especially after the ingestion of a large meal, is often observed. In some cases, the auscultatory and percussion sounds can be made to vary by changing the position of the patient or by the ingestion of food or large quantities of fluid. Borborygmus over the thorax, if present, is a valuable sign and is considered by some observers as pathognomonic of a diaphragmatic hernia. The affected part of the chest may appear enlarged and the abdomen occasionally may be found retracted. There may be tenderness in the upper part of the abdomen.

Table III

Associated Diseases	Number of Cases	Per Cent
Peptic Ulcer: Gastric 2, Duodenal 10	12	23
Cholecystitis, Cholelithiasis	12	23
Hernia: Inguinal 10, Umbilical 2	12	23
Chronic Appendicitis	9	17
Irritable Colon	7	13
Diverticulosis	6	11
Uterine Fibroids	3	6
Cardio-vascular Disease	3	6
Prostatic Hypertrophy	2	4
Cancer of the Stomach	2	4
Diverticulum of Lower Esophagus	1	2
Pernicious Anemia	1	2

Diagnosis

Roentgenological studies are indispensable for a diagnosis and therefore should be employed whenever diaphragmatic hernia is suspected. Many of these cases have been diagnosed only after one or more abdominal operations without relief of symptoms. Rarely is the hernia seen fluoroscopically with the patient in the upright position because the hernia is often reduced in that position. It is best observed by examining the patient in either the recumbent or Trendelenburg position. At times it may be demonstrated best by rotating the patient quickly from side to side, by deep inhalation and exhalation, straining, inflating the colon, producing abdominal constriction or by manual pressure over the stomach. When the hernial sac contains a little contrast media the gastric rugae may be observed, conclusive evidence that a portion of the stomach is above the diaphragm. One should note during the Roentgenoscopic examination whether the hernia reduces itself by change of position from lying to standing, by rotation, or by palpation, as these facts may be helpful in determining the presence or absence of adhesions and the possibility of incarceration or strangulation.

Roentgenologically, in the differential diagnosis, we must bear in mind the following conditions: (1) diaphragmatic hernia involving other than the esophageal orifice; (2) congenital shortening of the esophagus; (3) esophageal diverticulum involving the lower end of the esophagus; (4) cardio-spasm; (5) cardio-esophageal relaxation; (6) eventration of the left side of the diaphragm; and (7) diverticulum of the cardia of the stomach. Symptomatically, we must differentiate diaphragmatic hernia from peptic ulcer, gastric and esophageal cancer, gall-bladder disease, secondary anemia, reflex disturbances of the stomach caused by an irritable colon, and hyperchlorhydria; also from those thoracic conditions simulating it: pleurisy with effusion, pneumo-thorax, pulmonary cavitation and cardio-vascular disease.

Treatment

The treatment of diaphragmatic hernia requires careful consideration and study. The well being of the patient as a whole, rather than the prescribed treatment for the hernial condition, should be uppermost in the mind of the physician. Since many of these cases present the syndrome of peptic ulcer, gall-bladder disease or unstable colon, measures that are found successful in the treatment of those conditions often prove effective. In other words, the medical treatment is largely symptomatic. Since many of these patients have periods of quiescence and recurrences, the factors underlying these periods are of great importance. Attacks may be brought on by nervous and emotional upsets, states of mental and physical fatigue, and unhygienic habits. Many small hernias do well under medical treatment the aim of which is the avoidance of anything that is likely to increase intra-abdominal pressure. Food should be of a bland nature, taken in small amounts, at frequent intervals and eaten slowly. Complete co-operation of the patient is just as important in the treatment of this condition as in the successful management of peptic ulcer, diabetes, and pernicious anemia. If distress occurs during a meal, getting up and walking about for a few minutes will bring relief. Warm drinks and alkalies are also helpful. Anti-spasmodics and sedatives are frequently valuable. Tobacco should be forbidden entirely. The patient should be advised against retiring after a full, heavy meal at night and should preferably sleep with his head raised by several pillows, most of the time on his right side. If anemia is present, appropriate treatment should be prescribed.

Avoidance of strenuous exercise, heavy lifting, constipation, cathartic abuse, obesity and other con-

ditions that increase intra-abdominal tension is of great importance in the medical management of diaphragmatic hernia. Associated pathological entities such as peptic ulcer, diseased gall-bladder, irritable colon, chronic appendix or large pelvic tumor should receive proper treatment as they unquestionably cause aggravation of the hernia by reflex irritation of the stomach. Three patients of my series were completely relieved of symptoms after the removal of large uterine fibroids.

In the larger hernias with severe symptoms, not amenable to medical treatment, surgery is advisable if the condition of the patient permits. Operation should be undertaken only after serious study and consideration. Surgery in the treatment of diaphragmatic hernia even in the hands of the most competent surgeons is associated with a moderately high mortality and the possibility of recurrence. In only four cases of my series was surgical treatment necessary. It may be noteworthy that one of these patients, who in 1933 had the hernia repaired through the thoracic approach, had a recurrence of the hernia after a fall about six months later, but since has had only mild symptoms which respond to medical treatment.

In the traumatic cases the patient may be in severe shock and on examination a large part of the stomach and other abdominal viscera may be found in the chest. Such cases should be treated as any acute traumatic emergency without unnecessary delay.

Summary

This contribution is a clinical résumé of 53 cases of non-traumatic esophageal diaphragmatic hernia seen during the past 12 years. Numerous accounts of this clinical entity have been contributed by the Roentgenologist and surgeon but very few contributions have originated from the clinician although he, in most instances, is the first to see these cases.

The apparent increase in the reported incidence of diaphragmatic hernia is in reality due to the better appreciation of these cases by the clinician in differential diagnosis of vague complaints referred to the upper abdomen and lower chest, to the improved methods of Roentgenological diagnosis, and to the more painstaking abdominal explorations by surgeons during operations for other conditions.

The symptoms of diaphragmatic hernia are usually complex, slowly progressive and vary in type and intensity. They may be thoracic or abdominal in nature and at times they may be entirely absent and the discovery of a hernia, purely accidental. The symptoms present may simulate disease conditions of the abdomen and thorax.

We are justified in making a provisional diagnosis of diaphragmatic hernia on the basis of presented symptoms. A definite diagnosis of its presence must always be confirmed by careful Roentgenological study, unless this is contra-indicated.

The medical treatment of diaphragmatic hernia is largely symptomatic. Effort should be directed to the correction of associated disease conditions which may be largely responsible for the patient's complaints. Uncomplicated hernias do well under medical treatment. (Only four cases of this series required surgical intervention[2].)

Surgical treatment is advised when symptoms are severe and not controlled by medical management. The size of the hernia is no criterion in the decision for or against surgery. The possibility of carcinoma developing at the site of a gastric ulcer associated with diaphragmatic hernia is emphasized.

The importance of co-operation between clinician, Roentgenologist and surgeon in the diagnosis and management of diaphragmatic hernia cannot be over-estimated.

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THE RHODE ISLAND MEDICAL JOURNAL
Medical Library Building
106 Francis Street, Providence, R. I.

OUR HERITAGE

The resignation of Dr. Frederick N. Brown, for fifteen years Editor of the RHODE ISLAND MEDICAL JOURNAL, has been accepted by the Committee on Publication with the deepest regret.

It was in 1859 that the Rhode Island Medical Society voted that "a committee be raised to select and publish such papers in the archives of the society as they may deem worthy of presentation and also to prepare a sketch of the lives of eminent deceased physicians, from the first settlement of the colony, with an account of the medical institutions, and of other matters pertaining to the history of medicine in Rhode Island." The committee then raised, the original of the present Publication Committee, consisted of Usher Parsons, Isaac Ray and George L. Collins. So strenuous was their task that the report was published in 1877; a 474 page volume entitled "Communications of the Rhode Island Medical Society." Dating from the year 1859, the Society began publication of its *Transactions,* in parts issued quarterly and continued to the one hundredth Anniversary Meeting in 1912.

In January, 1900, the Providence Medical Association began to publish the bi-monthly *Providence Medical Journal,* with George D. Hersey, Editor, and Frederick T. Rogers, Business Manager. With these men in charge, the project could not but succeed. In 1912, by authority of the House of Delegates, it was made the Official Organ of the Rhode Island Medical Society and during the next four years published the papers and Transactions of the Society, edited successively by George D. Hersey, Frederick T. Rogers, and James W. Leech.

In November, 1916, the Journal was purchased by the Rhode Island Medical Society for the sum of one dollar and other valuable considerations, and in January, 1917, appeared as an enlarged monthly, RHODE ISLAND MEDICAL JOURNAL, under the editorship of Roland Hammond. In 1921, Frederick N. Brown undertook the office of Editor, which he was to continue for the memorable period of fifteen years. His resignation marks the end of the seventy-seventh year of the Rhode Island Medical Society's publications. We can still say, as did Dr. Hersey 38 years ago, in his first editorial, "As a matter of fact we are rather proud of the Journal, both of its appearance and contents."

Dr. Brown succeeded in office a notable line of editors, and, throughout his long term of service, has upheld the traditions of the Journal and of the Society. He has performed this task with tact and efficiency, and, through hearty and genial co-operation, has endeared himself not alone to those whom he has chosen as associates in the conduct of his office, but to the officers and fellows of the Society, with whom his position has brought him into frequent and intimate contact.

"DOCTOR"

In the future it may be an honor for a physician to be called "mister" as it is in England for surgeons. It just doesn't work to call these surgeons doctors. The title "doctor" means so little nowadays. In France, doctors are addressed "monsieur" or "monsieur le docteur," but the simple title doctor means little. Anyone who holds a doctor's degree is quite apt to use the title—clergymen, Ph.D.s, optometrists; and of course they are entitled to it. Perhaps we should be content to let patients speak of us as "doc" to distinguish ourselves from the "doctors" who are being created—faster than rabbits ever bred.

So much medical stuff and all of it so rotten. The *Pathfinder* magazine carries ads for cures for piles, epilepsy, gallstones, prostatic disease, alcoholism, asthma, how to get a baby, blood pressure, arthritis, sores and lumps. Doctor's shoes are advertised to a weary public. Of the five nationally advertised brands of "doctor" shoes, three are creations of now-deceased chiropodists who were not medical men. The *Shoe and Leather* Record, of London, states that the "doctor" brands of shoes "are based upon 'bolony'." The Tugwell amendment to the new Food and Drugs Act would have made shoes technically "drugs" but there are too many interests involved to permit such a bill to pass.

Built-in arches, all sorts of devices to deceive the public, can do more harm than good since each foot is different. It is impossible to prescribe a shoe to fit every need. Pathetic is the pilgrimage to Canada for foot twisting. Some New York hotels announce that buses run daily from New York to the Canadian joint. No doubt the psychologic effect is of benefit to some but when one sees a woman chasing over the roads for this sort of treatment when she is actually suffering from peripheral vascular disease it is pathetic to say the least.

M. W. T.

THE EDWIN SMITH SURGICAL PAPYRUS, WITH SOME REMARKS UPON EGYPTIAN MUMMIFICATION*

This papyrus, recently translated by Professor Breasted of the University of Chicago, has revolutionized our ideas of pre-Hippocratic surgery. It is an unfinished copy, made about 1700 B. C., of forty-eight cases of injury. The original observations were probably made in the IIIrd Dynasty and *may have been* made by Imhotep, or his immediate successors. The cases are arranged in rational fashion, beginning with minor injuries of the head, going on to the more severe, and progressing from the head to the thorax, where our copyist leaves off in the middle of a sentence. There is no magic whatsoever, but scientific, logical reasoning from cause to effect. The surgeon describes general and local signs and symptoms, gives either one of three prognoses: an ailment to be treated, to be contended with, or an ailment not to be treated, and then proceeds to recommend what would be considered quite modern handling of each case.

Mummification must have played some role in Egyptian conception of anatomy as the Egyptians were the only ancient people to remove the viscera after death. A study of the evolution of the technique shows gradual perfection up to the XXth Dynasty, then deterioration, with more attention paid to the external wrappings than to the preservation of the body itself. X-ray examination of five mummies in the Boston Museum of Fine Arts corroborated the studies made by Ruffer, G. Elliot Smith, and others.

C. A. McD.

*Breasted, James Henry. The Edwin Smith Surgical Papyrus. University of Chicago Press, Chicago, Ill., 1930.
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STREET LIGHTING

The apparent purpose of lights along the streets and highways is to protect the pedestrian. In general the lights are bright and unshaded. Every driver has had the sensation of relief on going from a lighted road to an unlighted one. These unshaded lights exactly defeat their own purpose. Light falling on a plane polished surface is regularly reflected, light falling on a dusty windshield (and whose windshield is not dusty?) is diffusely reflected, the greater part of the light being turned back in a definite direction. Auto lights by law are so shaded and reflected that they cause a minimum of glare under the circumstances.

Street lights are placed in such a position that a lateral beam is reflected from the windshield. This creates a zone between the street light and the approaching auto light, the center of which is occupied by the pedestrian. This zone has a very low visibility. On a rainy night where the dispersion of light is great, from the tiny rain drops, it is practically impossible to see a pedestrian walking beside the road. There is another angle too, in the problem of unshaded street lights. They cause a glare on the pupil of the eye which makes it contract. Thus the eye is a less efficient organ with which to see objects at the side of the road.

It would be interesting to examine the statistics of pedestrian accidents to find out what proportion of injuries occurred on unlighted streets as against those on lighted highways. Has it occurred to the various departments of safety to investigate this problem? A careful study of reflection of light, visibility of objects beside the road under various conditions, and the effect of unshaded lights along the road upon the pupils of the eyes of drivers, might bring up some worthwhile reforms in the way of street lighting.

Given a rainy night, with auto lights approaching, and a chain of unshaded street lamps on one's right, a pachyderm of noble proportions would be no more visible to the eye of a driver than one of Singer's midgets.

The reasonable solution of this problem would be street lights, with a softly colored shade, lighting the side of the road for the pedestrians' use, not a glaring, much diffused beam of light which seems to cast a Stygian umbra in the very place that needs good illumination most.

G. L. Y.

Rhode Island Hospital

On December 3, 1936, Dr. John S. Dziob of Woonsocket and Harvard Medical School, 1934, became Resident Physician at the Jane Brown Memorial. His internship at the R. I. Hospital terminated December 1.

Dr. Edward F. Ruhmann of Boston University Medical School, 1932, has opened an office for general practice at 1620 Broad Street. Dr. Ruhmann interned at the R. I. H. from February, 1933, to October, 1934, and was Resident Physician at the Jane Brown Memorial from October, 1934, to December, 1936.

Born on December 10, at the Lying-In Hospital, to Dr. and Mrs. McDougall, a daughter. Dr. McDougall is an intern at the R. I. H.

On December 15, 1936, Dr. Henry A. Campbell, of Central Falls, R. I., and Harvard Medical School, 1936, started a two year internship at the R. I. H.

Dr. and Mrs. Joseph F. Hawkins have gone to Florida for the Winter.

Drs. Shaw and Pickles have resumed practice after their recent illnesses.

Dr. Forest Martin was a recent visitor at the Hospital.

Dr. Herman A. Winkler is taking a post-graduate course in Bronchoscopy under Professor Chevalier Jackson at Temple University in Philadelphia. Dr. Winkler expects to resume practice about December 28, 1936.

In the *Journal A. M. A.* for December 19, Dr. Ralph Purvine has a well written report on "Fatal Poisoning from Sodium Dinitrophenol."

Providence Lying-In Hospital

At the regular Staff meeting, Wednesday, December 9, 1936, Dr. Alonzo K. Paine of Boston, was the guest speaker. He discussed a new method of the operative delivery of persistent posterior positions and illustrated the lecture by a number of excellent lantern slides. The method is a modification of Scanzoni manoeuvre in that forceps are applied upside down in the position in which the posterior occiput lies, and the head is brought down to the perineum outside of the bony pelvic outlet and then rotated to the anterior with the forceps, which will then lie in the correct position for delivery. This obviates taking off and reapplying the forceps, but one application being made. Doctor Paine is Professor of Obstetrics at Tufts Medical School. A film from the Chicago Lying-In Hospital showing the technic of forceps operation was shown.

Dr. Donald M. Beckwith, of Port Jefferson, Long Island, N. Y., is now resident surgeon.

Dr. LeRoy H. Wardner, of Saranac Lake, N. Y., began his internship December 1.

St. Joseph's Hospital

The monthly meeting of St. Joseph's Hospital Staff Association was held on Thursday, December 10, 1936. The meeting was called to order by Dr. William R. McGuirk, Acting President. The minutes of the previous meeting were read and accepted. Analysis of Hospital Services for November, 1936, was read, discussed and accepted. The annual report of the Secretary was read. On motion made by Dr. John T. Ward and seconded by Dr. William Hindle, the report was approved and accepted as read. The annual report of the Treasurer was read. On motion made by Dr. Andrew Mahoney and seconded by Dr. Vincent Oddo, the report was approved and accepted as read.

New Business: A communication from the Medical Board announcing Dr. Edward F. Burke as President and Dr. James H. Fagan as Secretary-Treasurer of St. Joseph's Hospital Staff Association was read by Dr. William R. McGuirk, Acting President, and accepted.

The paper of the evening, "Bleeding in Pregnancy," was presented by Dr. Andrew Mahoney, Obstetrical Department, followed by Motion Pictures of Post Partum Hemorrhage and Treatment. Discussion was opened by Dr. Frank S. Hale, who spoke on the indications for interference and treatment. Dr. Hale brought out the important points in blood pressure, pulse pressure, shock index, blood count, in the management of a case. Dr. Edward F. Burke spoke on Utero-Placental Apoplexy, including symptoms, pathology and treatment. Dr. James S. Manley spoke on Hydatidiform Mole and Chorio-Epithelioma. He reported two cases followed by Hysterectomy. Dr. James Hamilton reviewed the pathology and advised on treatment, cautioned against being too drastic. Dr. Andrew Mahoney closed the discussion by bringing out the fine points and explaining the pathology existing, necessitating surgery in the cases reported by Dr. James S. Manley.

On motion made by Dr. Vincent Oddo and seconded by Dr. James Hamilton, the meeting adjourned.

* * *

Dr. James S. Manley of New Bedford, Massachusetts, Resident Obstetrician, has received an appointment at the Rotunda Hospital, Dublin, Ireland, beginning March 1, 1937. Dr. Manley graduated from Boston College, and Tufts Medical School in 1931. He interned in St. Luke's Hospital, New Bedford, Massachusetts.

Dr. James B. Moran, Providence, Rhode Island, began his internship on November 1, 1936. He graduated from Providence College in 1932, and graduated from the University of Maryland in 1936.

Dr. Malcolm A. Winkler has returned from a tour of the hospitals in New York City.

Homeopathic Hospital of Rhode Island

The third lecture in the series under the direction of Dr. W. Richard Ohler arranged for the General Staff meetings of the Homeopathic Hospital of Rhode Island was given at the hospital Tuesday noon, Dec. 15th, by Dr. H. Houston Merritt of the Boston City Hospital, the subject being "Neurology as Applied to General Medicine."

Dr. Merritt described the simple tests which should be done in a routine examination and explained their significance. These included tests involving the cranial nerves such as pupillary reflexes, examination of the fundus of the eye, differentiating nerve and conductive deafness, facial movements, movements of the tongue, voice; examination of the motor system, noticing gait, weakness of arm movements, and grip; sensory tests with brush or wisp of cotton, differentiating sensation, or absence of sensation from pressure of the head or point of a pin, tuning fork on the shin as an aid in determining cord lesion, Romberg's test, reflexes of the knee-jerk, ankle-jerk, and plantar response (Babinsky's test).

Special attention was given to combined system disease, or cord degeneration, with pernicious anæmia. Other subjects discussed were multiple sclerosis, spinal cord tumors, cerebral and vascular lesions, including syphilis, dementia paralitica, tabes, and the examination of the comatose patient.

Dr. William H. Foley, formerly of the Charles V. Chapin Hospital, began his service as interne in the Homeopathic Hospital in December.

Minutes of the Caduceus Club

The monthly meeting of the Caduceus Club was held at the T. K. Club, December 14, 1936. The meeting was called to order by the President, Dr. Thaddeus A. Krolicki. The minutes of the November meeting were approved. Dr. Robert Henry, Chairman of the Banquet Committee, reported that the second annual banquet of the Club would be held at the To Kalon Club on January 11, 1937. Dr. Berlin and Dr. Blumgart of Boston have been invited to attend. Three physicians were unanimously elected to membership: Dr. Charles H. Holt, Dr. James L. Wheaton and Dr. Albert Vandale. It was voted by the Club, on recommendation of the Educational Committee, to adopt a uniform method of examination in regard to food handlers. Tests for Luetic and Neisserian infection have been included in this examination. Dr. Farrell, Chairman of the Publicity Committee, reported a gratifying response on the part of the public to the medical lectures sponsored by the Club. In cooperation with the Club, local druggists have offered to advertise the current lecture bi-weekly under the name of their drug firm. A collation was served, after which the meeting adjourned.

Respectfully submitted,

GEORGE B. MCCLELLAN, *Secretary*

Charles V. Chapin Hospital

Dr. William H. Foley, who served a short internship at this hospital and was then, on March 1, 1936, appointed resident in the psychopathic wards, left on November 30 to accept an internship at the Homeopathic Hospital.

Dr. Vincent P. Rossignoli commenced an internship here on September 1, 1936, and takes Dr. Foley's place. Dr. Rossignoli is a graduate of Providence College and Georgetown University Medical School. He served a rotating internship at The Hospital of St. Raphael in New Haven before coming here.

Dr. Francis A. DeCesare of Cranston began an internship December 1, 1936. He is a graduate of Providence College and the University of Naples in Italy.

Emma Pendleton Bradley Home

Dr. Dorothy G. Sproul, who has recently completed a short internship at the Emma Pendleton Bradley Home, has returned to take up her duties at the Children's Clinic of the University of California Hospital, San Francisco.

Dr. Lewis J. Schloss, who completed a six months internship at the Emma Pendleton Bradley Home on January 1, 1937, has started an eighteen months rotating appointment at the Newark Beth Israel Hospital, Newark, New Jersey.

MEMORABILIA

[*L., neut. pl. of memorabilis, worthy to be remembered or noted.*]

The American Association for the Study of Goiter again offers the Van Meter Prize Award of $300.00 and two honorable mentions for the best essays submitted concerning experimental and clinical investigations relative to the thyroid gland. This award will be made at the discretion of the Society at its next annual meeting to be held in Detroit, Michigan, June 14, 15, and 16. The competing manuscripts, which should not exceed 3,000 words in length, must be presented in English and a typewritten double spaced copy sent to the Corresponding Secretary, Dr. W. Blair Mosser, 133 Biddle Street, Kane, Pennsylvania, not later than April 1, 1937. Manuscripts received after this date will be held for competition the following year or returned at the author's request.

On January 7, our Historian, Dr. Walter L. Munro, starts on a world cruise, visiting Trinidad, Bahia, Rio de Janeiro, St. Helena, Cape Town, Durban, Madagascar, Seychelles, Bombay, Benares, Ceylon, Bangkok, Penang, Java, Sumatra, Bali, Singapore, Manila, Hongkong, Shanghai, Peping, Japan, Honolulu, Los Angeles, Balboa, Providence after five months.

November 27. A regular meeting of the Jacobi Medical Club of Rhode Island was held at the Miriam Hospital Annex, Dr. S. J. Goldowski spoke on "Cerebral Injuries."

December 8. The Amos Throop Club was entertained by Dr. Murray S. Danforth with motion pictures in color, illustrating a vacation trip through Norway, Sweden and Denmark.

December 11. At the meeting of the William W. Keen Medical Club, entertained by Dr. Paul C. Cook, an interesting report on the Second International Congress Against Cancer, which they attended at Brussels on September 20-26, was given by Drs. Herman C. Pitts, B. Earl Clarke and Russell Bowman.

December 14. At the meeting of the Thirty Four Medical Club, Dr. Frank W. Dimmitt spoke on "Acute Laryngeal Obstruction." The discussion was opened by Dr. K. K. Gregory.

* * *

Wednesday, December 16. At the John M. Peters House of the Rhode Island Hospital, Dr. Jacob Fine of the Beth Israel Hospital of Boston addressed the Rhode Island Fellows and Associates of the American College of Physicians on the absorption of air and gases from body tissues and viscera by the use of ninety-five per cent oxygen. Dr. Fine described experiments on animals and observations on human beings which showed that if ninety-five to ninety-eight per cent oxygen be inhaled, the nitrogen tension in the alveolar air is greatly reduced, causing a passage of nitrogen from the blood stream into the alveolar air and a reduction of nitrogen tension in the blood. Nitrogen gas in an obstructed small intestine tends then to pass into the blood stream, thus reducing gaseous distension. In animals in which nitrogen or air is injected either into the tissues or into the small intestine marked absorption takes place when the animal is breathing pure oxygen as compared with an animal breathing air in which there is relatively little absorption. Experiments on the distended stomach, however, showed but little absorption regardless of whether the animal breathed oxygen or air.

Dr. Fine showed that nitrogen is the gas most frequently found in bowel obstruction and that if hydrogen or oxygen be injected a good part of such gas will be replaced by nitrogen. He presented data on several clinical cases of obstruction in human beings in which the breathing of ninety-five per cent oxygen for from twelve to twenty-four hours produced definite amelioration of distension. In discussing encephalography Dr. Fine showed that absorption of the air injected can be greatly facilitated by three or four hours of this type of oxygen treatment with marked relief of headache. Even if oxygen has been used for the encephalogram, he showed that it is replaced by nitrogen and the need of aid in the absorptive process remains.

At the meeting, Dr. Charles F. Gormly was elected Chairman, and Dr. Cecil Dustin, Secretary. Dr. Guy W. Wells was elected Chairman of a program committee of four members; Dr. Wells, Dr. Alex. M. Burgess, Governor of the College for Rhode Island, and the Chairman and Secretary of the Rhode Island group, ex-officio.

* * *

December 18. With the subject "Endometriosis," Dr. Herman C. Pitts described the adenomas of the endometrial type, at the regular meeting of the Friday Night Medical Club. Dr. B. Earl Clarke discussed the pathological features and demonstrated microscopical specimens of the condition. It has been unusually prevalent in this community during the past year.

December 23. The Jacobi Medical Club met at the Miriam Hospital Annex. Professor J. I. Jankelson, of Tufts Medical College, gave the address; his subject, "Differential Diagnosis of More Common Conditions in the Abdomen."

RECENT BOOKS

UROLOGICAL ROENTGENOLOGY, A MANUAL FOR STUDENTS AND PRACTITIONERS. By Miley B. Wesson, M.D., Ex-President, American Urological Association; and Howard E. Ruggles, M.D., Roentgenologist to University of California Hospital and St. Luke's Hospital, and Clinical Professor of Roentgenology, University of California Medical School. Octavo, 269 pages, with 227 engravings. Cloth, $5.00, net. Philadelphia, Lea and Febiger, 1936.

This is a very fine and useful book. It presents a "bird's-eye view" of urologic surgery from the stand-point of diagnosis; emphasizes possible mistakes in technique and interpretation; and discusses in detail the methods, armamentarium, indications, contra-indications and dangers of the various forms of urologic diagnosis.

As the title indicates, the volume concerns itself mainly with urologic roentgenology, not with treatment. Rarely have we seen such a valuable collection of interesting and characteristic roentgenographs. The pictures are clear, technically excellent, and instructive. The pathology of urology is graphically illustrated in each chapter, every warning given, and every disease described being demonstrated by an accompanying roentgenograph. Indeed, if one were to examine only the x-ray studies, with their accompanying descriptions, and were to ignore the text completely, he would be well rewarded.

We recommend this book to the young urologist, and to the profession at large, but especially to the general surgeon who may desire to improve his understanding of the proper interpretation of pyelograms, cystograms and urethrograms. Here he will find, in compact form, excellent examples of every urologic disease, including such rarely diagnosed conditions as chyluria, and aneurysm of the renal artery.

We suppose that it would be impossible to write a brief text, covering any subject as profound as urological roentgenology without, at times, becoming didactic. This volume is no exception, and at times we wish that we might have either the privilege of a more detailed description, or the opportunity of disagreeing with certain observations and conclusions. For example, in discussing hydronephrosis, we find the statement that the obstruction may be partial or complete, but must be constant "and have existed over a considerable period of time." What is meant by "a considerable period of time"? We have seen hydronephrosis develop within two or three days and believe it may develop in less time than that. And again, "Long continued colon bacillus infection in many cases produces renal mobility and sagging of the kidneys, which is responsible for the obstruction of the urinary flow and the resultant dilatation of the kidney pelvis. A marked ureteritis frequently causes a "pipe stem ureter." We believe that infection per se in most instances produces fixation, rather than mobility; and we are of the firm opinion that the ureteritis, with its accompanying edema, rather than a postulated and unexplained renal mobility, is the true cause of "the obstruction of the urinary flow and the resultant dilatation of the kidney pelvis."

However, in spite of such differences as we may have with certain of the authors' explanations and statements, the main purpose of the book, namely, the presentation of comprehensive roentgenograms illustrative of urological pathology, is more than well done. We have studied their work with pleasure and profit, and we recommend it without reservation.

ROBERT R. BALDRIDGE.

THE 1936 YEAR BOOK OF GENERAL MEDICINE. Edited by George F. Pick, M.D., Lawrason Brown, M.D., George R. Minot, M.D., S.D., F.R.C.P. (Hon.) Edin., William B. Castle, M.D., A.M., M.D. (Hon.) Utrecht, William B. Stroud, M.D., George B. Eusterman, M.D. The Year Book Publishers, Incorporated, 304 South Dearborn Street, Chicago. 1936. pp. 848. Cloth, $3.00.

This annual compact summary of articles written in the preceding year needs no introduction to most practitioners. Its excellence has been demonstrated in the past by the concise manner in which the articles have been abstracted, and by the way in which the essential elements of the original author's work have been maintained. At the end of an article occasionally there appears some comment by one of the Editors who are among the outstanding physicians of the country. These remarks are pithy, and, on the whole, add to the general context. To make the book more readable, the articles are grouped into subjects, such as infectious diseases, diseases of the chest, bronchi, blood, kidney, etc. A note at the foot of the page gives the journal reference in case the original article is to be consulted. Diagrams and photographs are given where needed to amplify the text. There is an adequate index. This book is recommended to those whose interest is particularly in medicine, and who desire to keep up to date. It makes an excellent reference book.

F. H. C.

A TALK TO THOSE ABOUT TO WED. By Addison W. Baird, M.D. Furnished at cost to Physicians, Clergymen, Teachers and Leaders in Social Betterment but not advertised. The Addison Press, 12 East 86th Street, New York. 1936. Pamphlet, pp. 15. Ten cents.

This little pamphlet of 15 pages is presented by a practicing physician after a long and active professional life. Dr. Addison Baird has given a most sane and sensible treatment of this matter. He has pointed out in the first few pages some pitfalls which lie in the way of young people, and has given in the later pages, a direct presentation of the facts of marriage as it seems to me they should be presented by the good physician.

His closing words will show the purpose which underlies the writing of this pamphlet, "Thus I close where I began, with an ardent desire to see worthy young men and young women safely married, with an earnest purpose to make clear what they may expect in the intimate married relation, and with a lively hope that through love and loyalty each couple will enjoy an immeasurable physical, mental and spiritual happiness.

It seems to us that this is a very ethical and proper presentation of the subject.

GEORGE W. WATERMAN.

PROVIDENCE MEDICAL ASSOCIATION

Minutes of the December Meeting

The regular monthly meeting of the Providence Medical Association was called to order by the president, Dr. William S. Streker, on Monday, Dec. 7, 1936, at 8:50 P. M. The minutes of the last meeting were read and approved. Their applications having been approved by the Standing Committee, the following were elected to membership:

Giovanni Capobianco
Robert Gordon Murphy
Thomas Patrick Sheridan
Philip Solomon
Arthur Hilton Vaughn

The following obituaries were read: of Edward J. Logan by Dr. Fred A. Coughlin; of William McDonald, Jr., by Dr. Niles Westcott; and of James W. Leech by Dr. Edward S. Brackett. It was voted to spread these on the records and to send copies to the families.

Dr. Halsey DeWolf reported on the work of the Committee on the Advisability of a Plan for the Medical Care of the Low Income Group. It was voted to accept this statement as a preliminary report.

The President announced the appointment of the following Obituary Committees: for the late Dr. Augustus W. Calder—Drs. Albert A. Barrows and William P. Davis; for the late Dr. W. Louis Chapman—Drs. Frank E. McEvoy and Charles E. Hawkes; and for the late Dr. John G. O'Meara—Drs. Richard F. McCoart and Charles A. Gannon.

The first paper of the evening was read by Dr. Vincent J. Oddo and was entitled "Transurethral Resection of the Prostate Gland—A Conservative Evaluation." The speaker advocated a conservative attitude with careful selection of patients and careful pre-operative preparation. He reported the results obtained in 75 cases during the last 6 years; of these 75 patients 12 had malignant disease of the prostate. There was no immediate mortality. Low spinal anaesthesia was used in most cases. He discussed the technic of operation, the post-operative care, and post-operative complications. The paper was discussed by Drs. Kerney, Howard K. Turner and Wm. A. Mahoney.

The second paper of the evening was read by Dr. James P. O'Hare, Assistant Professor of Medicine at Harvard Medical School, and was entitled "Interesting Problems in Hypertension and Bright's Disease." The speaker outlined the history of several unusual and interesting cases coming under his care and observation over a period of years; including a case of glomerulo-nephritis of 20 years' duration, nephrosclerosis, hypertensive encephelopathy, nephrosis, and vascular hypertension in a young woman of 24 who went through normal pregnancy without disaster or progression of the disease. Dr. O'Hare discussed various aspects of disease illustrated by these cases, commenting on unusual or striking features in a very interesting and enlightening manner. The paper was discussed by Drs. Wells and Burgess.

The meeting adjourned at 10:45 P. M. Attendance 137. Collation was served.

Respectfully submitted,

HERMAN A. LAWSON, *Secretary.*

PUNCTUALITY

It is the duty of a physician, particularly in the instance of a consultation, to be punctual in attendance. When, however, the consultant or the physician in charge is unavoidably delayed, the one who first arrives should wait for the other for a reasonable time, after which the consultation should be considered postponed. When the consultant has come from a distance, or when for any reason it will be difficult to meet the physician in charge at another time, or if the case is urgent, or if it be the desire of the patient, he may examine the patient and mail his written opinion, or see that it is delivered under seal, to the physician in charge. Under these conditions, the consultant's conduct must be especially tactful; he must remember that he is framing an opinion without the aid of the physician who has observed the course of the disease.

—From the Code of Ethics of the A. M. A.

OBITUARY

DR. WILLIAM McDONALD

On August 1, 1936, there died at Marion, Mass., after a long illness, William McDonald, Jr., M.D., scientist, philosopher and physician. Born in Albany, N. Y., June 2, 1873, he studied in Albany schools, Brown University (class of 1895), College of Physicians and Surgeons of Columbia University, receiving a Diploma in Medicine and a Master's Degree in Arts in the same year, 1899. He was interne at the Rhode Island Hospital, 1899-1901; resident and later Clinical Director at Butler Hospital, 1901 to 1909. At this time, 1909, he entered the practice of neurology and psychiatry in Providence. He was Visiting Neurologist to the Rhode Island Hospital and to the Memorial Hospital, Pawtucket. Following the explosion at Halifax he organized the neurological clinic for the victims of that disaster. He later was commissioned Captain in the U. S. Army and was overseas serving with the 1st, 2nd and 3rd Armies. He was credited with two battle stars, returning with a commission as Major, M. C. In 1919 he was assigned command of the Neurological and Psychiatric Division at the Walter Reed Hospital in Washington. Later in the same year he was discharged and placed on inactive duty as Senior Surgeon, Public Health Service.

In 1919-20 he made a survey of nervous and mental diseases in North Carolina under the auspices of the National Committee for Mental Hygiene. In 1920 and 1921 he lectured on neurology at the School of Medicine, Yale University, and was Visiting Neurologist at the New Haven Hospital.

In 1921 he practically gave up active practice, failing health and eyesight forcing him to limit his work. A brilliant, thorough worker in whose plans time was of little account, he gave his attention as best he could to a few selected cases, particularly those with the neurological problems following anterior poliomyelitis and encephalitis. Four years ago physical handicaps became too great for him to carry on and at length none of his dearest friends could wish him a continuation of his misery.

He married, February 18, 1909, Elizabeth Merchand Hurkamp of Fredericksburg, Virginia, who died two years ago following a long, painful illness. There are no children.

Dr. McDonald contributed numerous carefully prepared articles to the literature of medicine, particularly to the American Journal of Insanity and our own Medical Journal. He made thorough studies of general paresis, the psychoneuroses, paranoia, the symptomatology of brain tumors and the particulars of aphasia. His work is a monument of careful search for facts and accurate deduction. It is hoped that a detailed study of his work may be made and presented to us.

NILES WESTCOTT, M.D.